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Cognitive–Behavioral Couple's Treatment for Posttraumatic Stress Disorder: Initial Findings

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This pilot study was an initial investigation of Cognitive–Behavioral Couple's Treatment (CBCT) for posttraumatic stress disorder (PTSD). Seven couples in which the husband was diagnosed with PTSD secondary to Vietnam combat experiences completed the treatment. According to independent clinician assessment and partner report, the veterans had substantial improvements in their PTSD symptoms. The veterans reported less dramatic improvements in their PTSD symptoms, but endorsed significant improvements in their depression and anxiety. The partners reported improved relationship satisfaction, whereas the veterans' relationship satisfaction was unchanged across treatment. The current findings are compared with findings on other forms of empirically validated treatment for PTSD and previous studies of CBCT for various individual problems. Theoretical implications and future directions are offered.

KEY WORDS: PTSD; couples; treatment outcomes.

Posttraumatic stress disorder (PTSD) has been associated with a myriad of intimate relationship problems, leading a number of researchers and clinicians to encourage inclusion of traumatized individuals' partners in treatment (e.g., Johnson, 2002; Riggs, 2000). However, relatively few empirical studies have investigated partner-incorporated PTSD treatment. Two controlled (Glynn et al., 1999; Sweany, 1987) and two uncontrolled (Cahoon, 1984; Rabin & Nardi, 1991) studies of couples' therapies not specifically designed for PTSD have shown some promise in ameliorating PTSD. The best controlled of these studies found an effect size advantage for behavioral family therapy as an adjunct to exposure treatment (Glynn et al., 1999).

Cognitive–Behavioral Couple's Treatment (CBCT) has been demonstrated to be as efficacious as individual psychotherapy in treating several disorders (i.e., depression, panic disorder/agoraphobia, substance abuse), with additional benefits of improved relationship satisfaction, parenting, and treatment delivery (e.g., cost savings, efficiency, less attrition), and reduced relapse and physical aggression (e.g., Daiuto, Baucom, Epstein, & Dutton, 1998; Jacobson, Dobson, Fruzzetti, Schmaling, & Salusky, 1991; O'Farrell & Fals-Stewart, 2000). Our CBCT specific to PTSD recognizes that couple's behaviors and belief systems interact and reciprocally maintain relationship discord and PTSD symptoms. Thus, the behavioral and cognitive interventions are aimed at the dyad, and at simultaneously improving PTSD symptoms and relationship discord. The theoretical rationale underlying CBCT for PTSD and its related interventions are more fully described by Monson, Guthrie, and Stevens (2003).

In an initial step to determine the efficacy of CBCT for PTSD, the primary hypotheses of this study were that

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the treatment would result in improvements in the PTSD-identified partners' PTSD symptoms and the couples' relationship satisfaction. Secondary hypotheses included predicted improvements in comorbid conditions (i.e., depression, anxiety).

Method

Participants

Seven couples in which at least one member of the couple was identified to have PTSD secondary to military-related trauma were recruited from within a Veterans' Affairs (VA) Medical Center. All of the participants were heterosexual and married, and the husbands were diagnosed with PTSD secondary to Vietnam combat experiences. The participants were Caucasian, and the mean ages of the husbands and wives were 56 (range = 53–58) and 51 (range = 42–59) years, respectively. Their median length of marriage was 29 years (range = 2–35). Three couples had a history of physical aggression, and three veterans were previously divorced. The VA rated five of the veterans as 100% permanently disabled and one was rated as 50% disabled of their military service-related PTSD. The remaining veteran received non-VA entitlements for physical disability.

Measures

The Clinician Administered PTSD Scale (CAPS; Blake et al., 1995) is a semistructured clinician interview that measures PTSD diagnostic status and symptom severity consistent with the *Diagnostic and Statistical Manual—Fourth Edition.* (*DSM-IV*; American Psychiatric Association, 1994). PTSD diagnostic status was based on a minimum level of severity (overall severity = 45) and *DSM-IV* symptom criteria (symptom frequency = 1 and intensity = 2 to be counted) on CAPS. Total CAPS symptom severity was the primary outcome. The PTSD Checklist (PCL; Weathers, Litz, Herman, Huska, & Keane, 1993) is a 17-item self-report measure of the PTSD symptoms found in the *DSM-IV*. Partner ratings of the PTSD-identified veterans' symptoms were also obtained using the PCL. The Beck Depression Inventory (BDI; Beck, Ward, Mendelsohn, Mock, & Erbaugh, 1961) is a 21-item self-report measure designed to assess degree of depressive symptomatology. The Spielberger State-Trait Inventory (STAI-T) (Spielberger, 1983) consists of two 20-item scales: State Anxiety and Trait Anxiety. Only the Trait Anxiety scale was used in this study, because of its greater test—retest reliability (.81 vs. .40 for State Anxiety). The Dyadic Adjustment Scale (DAS; Spanier, 1976) is a 32-item self-report inventory designed to measure satisfaction in intimate dyads. Scores <100 represent the Dissatisfied range. The psychometric properties of the measures used in this study have been well established (Beck, Steer, & Garbin, 1988; Crane, Allgood, Larson, & Griffin, 1990; Forbes, Creamer, & Biddle, 2001; Spielberger, 1983; Weathers, Keane, & Davidson, 2001).

Procedure

Inclusion criteria were a current diagnosis of military-related PTSD and an intimate partner willing to participate in treatment. Exclusion criteria for both the PTSD-identified participant and partner included substance abuse/dependence not in remission for at least 3 months, current uncontrolled bipolar or psychotic disorder, or severe cognitive impairment. Couples experiencing severe intimate aggression or a desire to separate or end their intimate relationship were also excluded. Independent clinician interview for PTSD diagnosis, self-report assessment (Revised Conflict Tactics Scale; Straus, Hamby, McCoy, & Sugarman, 1996), and medical record review were used to establish the inclusion and exclusion criteria. Assessments were conducted pre- and posttreatment. Trained psychology doctoral students uninvolved in the study and blind to assessment period conducted the CAPS.

CBCT for PTSD consists of 15 sessions comprising three treatment phases: (1) treatment orientation and psychoeducation about PTSD and its related intimate relationship problems; (2) behavioral communication skills training; and (3) cognitive interventions. Following the first two sessions focused on the treatment rationale and psychoeducation, conjoint behavioral interventions are aimed at overcoming experiential avoidance and improving communication skills. In the ninth session, cognitive interventions are introduced to modify core interacting schemas associated with the development and/or maintenance of PTSD and relationship discord. All seven couples received the manualized treatment more fully described elsewhere (Monson, Guthrie, & Stevens, 2003). The treating authors observed each other's treatment sessions to ensure adherence to the treatment. These treatment cases were also used to further refine descriptions in the treatment manual available from the first author.

Results

Paired sample *t*-tests were used to test pre–post change, and paired sample effect sizes (*d*) were calculated to assess the magnitude of change. Given the small sise

Table 1. Treatment Outcomes for Cognitive—Behavioral Couple's Treatment for posttraumatic stress disorder (PTSD)

	Pretreatment		Posttreatment				
	M	*SD*	*M*	*SD*	*t*(6)	*d*	Reliable change[a]
PTSD symptoms							
Clinician (CAPS)	74.57	20.77	52.57	32.21	3.91**	1.60	7 improved
Self-report (PCL-S)	51.29	11.16	45.57	11.73	1.57	0.64	4 improved, 1 deteriorated
Partner-report (PCL-P)	57.43	13.96	35.14	13.62	2.88*	1.18	5 improved
Depression (BDI)	23.71	11.70	17.43	9.54	3.79**	1.55	5 improved
Anxiety (STAI-T)	65.29	27.20	54.86	27.93	2.48*	1.01	3 improved
Relationship satisfaction (DAS)							
Veteran	108.00	6.90	107.57	7.63	0.13	0.05	2 deteriorated
Partner	104.00	7.39	110.43	7.81	−2.25+	−0.92	3 improved

Notes. $N = 7$ couples. CAPS = Clinician Administered PTSD Scale. PCL-S = PTSD Checklist self-report. PCL-P = PTSD Checklist partner-report of veterans' symptoms. BDI = Beck Depression Inventory. STAI-T = State-Trait Anxiety Inventory—Trait Scale. DAS = Dyadic Adjustment Scale (higher scores indicate greater satisfaction).
[a]The reliable change criteria were CAPS ± 9, PCL ± 5, BDI ± 5, and STAI-T ± 6 points.
$^{+}p = .07$. $^{*}p < .05$. $^{**}p < .01$.

of the study, we also examined change on an individual basis for each outcome, using reliable change (improvement or deterioration) criteria calculated and used in recent research (see Foa, Zoellner, Feeny, Hembree, & Alvarez-Conrad, 2002, for more information on calculations).

As shown in Table 1, there were statistically significant improvements in the clinician (CAPS) and partner (PCL-P) ratings of the veterans' PTSD symptoms, with effect sizes greater than 1.0. The veterans' self-reported improvements in PTSD symptoms (PCL-S) were not significantly significant. Using the reliable change criteria for PTSD symptoms, all seven veterans were improved according to the clinician assessors (CAPS), five were improved according to the partners (PCL-P), and four were improved according to self-report (PCL-S). One veteran reported deterioration in his symptoms. Three veterans no longer met criteria for PTSD diagnosis at the end of treatment.

The veterans self-reported statistically significant improvements in depression (BDI) and anxiety (STAI-T), with effect sizes greater than 1.0. According to the reliable change criteria, five and three of the veterans reported improvements in their depression and anxiety, respectively.

Improvements in the partners' relationship satisfaction (DAS) were marginally significant, whereas the veterans' relationship satisfaction did not change across treatment. Using the reliable change criteria, three partners reported improvements and two veterans reported deteriorations in their relationship satisfaction.

Discussion

This pilot study offers preliminary support for the use of CBCT for PTSD in veterans with chronic and severe PTSD. According to the independent assessors and the veterans' partners, the veterans had significant improvements in their PTSD symptoms. These findings are consistent with previous controlled trials of individual cognitive–behavioral and program evaluation studies of PTSD treatment with veterans (e.g., Glynn et al., 1999; Keane, Fairbank, Caddell, & Zimering, 1989; Rosenheck & Fontana, 2002). As found in previous outcome studies, self-reported improvements in PTSD symptoms were not as dramatic (Forbes et al., 2001; Van Etten & Taylor, 1998). However, the veterans self-reported significant improvements in their depression and anxiety.

These gains were found with couples predominantly satisfied with their relationship at intake. This contradicts results from studies of CBCT for depression, wherein pretreatment satisfaction is associated with less robust improvements in depression (Jacobson et al., 1991). However, our findings are in line with studies of partner-assisted treatment for agoraphobia showing pretreatment satisfaction to be associated with greater treatment gains (Daiuto et al., 1998). Further investigation into the role of relationship satisfaction in treatment outcomes is warranted in lieu of the discrepant changes in the veterans' and partners' satisfaction over the course of the treatment.

This study has a number of limitations related to its uncontrolled, pre–post design. A larger controlled trial with follow-up assessment will provide more support for the efficacy of the treatment. Moreover, the applicability of this treatment for different types of trauma, couples with greater relationship discord, and couples in which both members are diagnosed with PTSD is not yet known. Future research should evaluate additional treatment benefits, including potential improvements in partner psychopathology, psychosocial functioning, and treatment

delivery. Exploration of these avenues will further illuminate the complex interplay between PTSD and intimate relationship functioning.

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